# *LOS ANGELES COUNTY COMMISSION ON HIV*

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## PRIORITIES AND PLANNING (P&P) COMMITTEE MEETING MINUTES

August 23, 2011

| MEMBERS PRESENT | MEMBERS ABSENT | PUBLIC | HIV EPI AND OAPP STAFF |
|---|---|---|---|
| Al Ballesteros, *Co-Chair* | Douglas Frye | Aaron Fox | Dave Young |
| Bradley Land, *Co-Chair* | Quentin O'Brien | Miki Jackson | |
| Michael Johnson | | Luke Klipp | |
| David Kelly | | Scott Singer | **COMM STAFF/ CONSULTANTS** |
| Ted Liso | | Jason Wise | |
| Anna Long | | | Jane Nachazel |
| Abad Lopez | | | Glenda Pinney |
| Carlos Vega-Matos | | | Diane Tan |
| Tonya Washington-Hendricks | | | Craig Vincent-Jones |

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2) **Minutes**: Priorities and Planning (P&P) Committee Meeting Minutes, *6/28/2011*
3) **Minutes**: Priorities and Planning (P&P) Committee Meeting Minutes, *7/19/2011*
4) **Minutes**: Priorities and Planning (P&P) Committee Meeting Minutes, *7/26/2011*
5) **PowerPoint**: Medical Case Management & Early Intervention Services Overview, *8/23/2011*
6) **Memorandum**: Ryan White Part A Minority AIDS Initiative (MAI) Allocations, *8/22/2011*
7) **Table**: OAPP Recommendations for YR 22 Ryan White Part A MAI Allocations, *8/22/2011*
8) **Memorandum**: Minority AIDS Initiative (MAI) Plan for Fiscal Years 2010-2012: Recommendations for Commission Approval, *10/8/2009*
9) **Report**: 2008 Part A MAI Yearend, Los Angeles, CA, H3MHA08446, *1/25/2010*
10) **Report Narrative**: FY 2008 Minority AIDS Initiative Annual Report Narrative, *1/25/2010*
11) **Brief**: Program/Planning News: HCR Task Force Guidance for FY 2011-2012 Priority- and Allocation-Setting, *7/17/2011*
12) **Memorandum**: FY 2012 Priority- and Allocation-Setting (P-and-A) Contingency Scenarios, *8/1/2011*
13) **Table**: FY 2012 Ryan White Part A/Part B SAM Care Allocations/Expenditures, *7/26/2011*
14) **Table**: FY 2012 Contingency Scenario Forecasting, *7/26/2011*

1. **CALL TO ORDER**: Mr. Land called the meeting to order at 12:40 pm.

2. **APPROVAL OF AGENDA**:
**MOTION #1**: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES**:
**MOTION #2**: Approve the 6/28/2011, 7/19/2011 and 7/26/2011 Priorities and Planning (P&P) Committee Meeting Minutes **(*Passed by Consensus)***.

4. **PUBLIC COMMENT, NON-AGENDIZED**: There were no comments.

**5. COMMISSION COMMENT, NON-AGENDIZED**: Mr. Johnson praised P&P on its P-and-A process and Commission presentation.

**6. CO-CHAIRS' REPORT**:
- Mr. Land noted the FY 2011 Notice of Grant Award had not yet been received, so allocation review remained deferred.
- He added he would not be available for the September meeting. Mr. Johnson said he would attend to assist Mr. Ballesteros.

**7. MINORITY AIDS INITIATIVE (MAI)**:

**A. Medical Case Management (MCM)**:
- Mr. Vega-Matos gave a combined presentation on MCM and Early Intervention Services (EIS) to review investments, utilization patterns and inform discussion on solutions to challenges and barriers in delivery of and access to services. Data was from service utilization in years 2007, 2008, 2009; preliminary Casewatch and internal OAPP reports from 2010 and 2011; and program monitoring.
- MCM helps consumers maximize treatment benefits by removing barriers to adherence. Eight providers are funded.
- OAPP is reviewing why two or three providers did not maximize their 2010 MCM grants. Expenditures increased in 2011 due to the start of the new SPA 1 services and a new Nurse Case Manager with at the Sheriff's Department.
- Mr. Vega-Matos noted that MCM services in 2008, 2009 and 2010 data will always require footnotes due to system changes. Overall, clients are predominantly male Latino or African-American (AA). OAPP is reviewing several anomalies, such as why female and Latino client numbers dropped by half from 2007 to 2008, then rebounded in 2009, and why encounters declined from 2008 to 2009, but client numbers increased. 2010 data will be available shortly.
- OAPP is working with providers to better define nurse case management versus clinic roles. This has been a challenge as there is always a shortage of clinic nurses, so nurse case manager duties can be diverted to clinical responsibilities.
- There has also been a lack of standardization in assessment and MCM acuity tools and protocols. OAPP is working with providers to streamline and standardize them, including performance measures.
- Four MCM providers with non-medical case management contracts have begun integrating the two service models into a Medical Care Coordination (MCC) approach. OAPP is working with them to develop an integrated tool and is providing them Technical Assistance (TA).
- Mr. Ballesteros asked if a MCM visit is considered a clinic visit. Mr. Vega-Matos said it varies by provider and patient acuity mix. Mr. Vincent-Jones noted encounters may have increased if providers previously counted a visit as a medical visit and now count it as an MCM visit. Mr. Vega-Matos said OAPP is working to link acuity with the number and type of visits.
- Mr. Johnson noted a disease registry would provide the data needed. The Department of Health Services (DHS) and the Low Income Health Program (LIHP) will both be using the same registry, so it would make sense for the RW system to adopt it as well. The disease registry details what each member of a care team should be doing for each patient. Mr. Vincent-Jones cautioned that the Commission has limited authority to address data management issues.
- Mr. Vega-Matos noted data management and exchange for a registry is complex, so cannot be done quickly, especially for clinics with other data management systems. MCM focuses on specifics such as treatment adherence and referrals and is being further defined with migration to MCC.

**B. Early Intervention Services (EIS)**:
- Mr. Vega-Matos noted there were originally six EIS providers, but Prototypes surrendered their contract following budget cuts. Prior to 2010, most EIS was funded directly by and reported to the State so data for those years is incomplete. MAI funds are used for services to the AA and Latino EIS clients—which form a majority of EIS clients—but services are not denied regardless of race.
- EIS programs lack standardization of purpose, staffing, tools and approaches. Some are mostly medical outpatient clinical visits with a small outreach component. Some do outreach within the clinic. Newer programs have more external outreach. Legacy programs focused on keeping people connected to care as care was scarce then.
- OAPP is providing significant TA focused on outreach for patients new to care, newly diagnosed or out of care for more than six months. OAPP is either developing outreach plans for programs or requiring them to develop plans for OAPP approval. Some programs are being changed altogether, e.g., Hubert H. Humphrey Comprehensive Care Clinic services are predominantly Medical Outpatient (MO), so they are being transitioned from EIS to MO.
- An internal OAPP work group is reviewing research to align services with the National HIV/AIDS Strategy (NHAS) and Testing and Linkage to Care Plus (TLC+). OAPP is also working with the Standards of Care (SOC) Committee to combine

EIS, Outreach and Treatment Education into a Linkage To Care (LTC) standard. SOC also plans an Expert Review Panel for the development of this new standard.

- Mr. Vincent-Jones asked how to address EIS funding since current EIS funds have supported other categories, such as MO. Mr. Vega-Matos said he will develop recommendations as the various components are teased out for different populations. Mr. Singer asked if MO funding would suffer as, e.g., Humphrey CCC EIS client funding moves to MO. Mr. Young noted Humphrey CCC Part B/SAM Care funding will shift to Part A and will be facilitated by funding savings resulting from the migration of patients to Healthy Way LA.

➲ Mr. Vega-Matos will refine the presentation slides and return them for website posting.

**C. FY 2012 MAI Plan**:

- Mr. Vincent-Jones noted P&P has now heard presentations on all MAI allocated services as requested to inform review and evaluate the MAI allocation plan.
- OAPP recommended retaining current categories with allocation adjustments to reflect service utilization realities by increasing Oral Health (OH) from 20% to 30%, reducing EIS from 35% to 25% and continuing MCM (MCC) at 45%.
- Mr. Vega-Matos noted all are high priority. He felt other allocations assumed relative MAI funding stability, which is key in this time of change. OH expansion will increase capacity for dentists, dental assistants and hygienists, and for front office staff in order to ensure that calls are answered in a timely manner.
- Mr. Vega-Matos noted that HRSA requires reporting it medical case management (MCM) separately from non-medical case management. Contracts reflect that, but both are MCC components. MAI is now funding the MCM component of MCC. Mr. Vincent-Jones indicated that due to the change in service category, the allocation would need to be MCC, but could be restricted to the MCM component if the Committee and/or OAPP desired it.
- Ms. Washington-Hendricks asked about OH, especially services per the FY 2008 MAI Annual Report Narrative, page 2, last paragraph, regarding education and prevention, including nutritional counseling. Mr. Vega-Matos said the goal is to increase both clients and procedures. OH providers provide oral health education, and link with MO if needed for nutrition counseling. Mr. Johnson felt nutrition counseling should be better linked to OH to ensure nutrition issues do not impede OH care.
- Mr. Singer asked if more EIS funds could support Outreach in line with NHAS goals. Mr. Vincent-Jones noted EIS will shift into LTC in the next six months, which will both address NHAS and possibly expand the availability of any funding savings from the LIHP migration.

**MOTION #3**: ***(Ballesteros/Land)*** Retain FY 2011 MAI Plan service categories for the FY 2012 MAI Plan as follows: Oral Health (OH), Early Intervention Services (EIS) and Medical Care Coordination (MCC) [for Medical Case Management (MCM)] **(*Passed: Ayes,*** Ballesteros, Johnson, Kelly, Land, Liso, Long, Lopez, Vega-Matos, Washington-Hendricks***; Opposed,*** none***; Abstentions,*** none**)**.

**D. FY 2012 MAI Priority- and Allocation-Setting**:

- Mr. Young noted that OAPP had requested HRSA approval to carryover MAI YR 3 savings of $269,785 from EIS in FY 2010. Approval was not received in time, so regular MAI funds were used. Carryover funds now must be used by 2/28/2012.
- OAPP recommended using funds for OH consistent with the FY 2011 MAI carryover plan and FY 2012 Part A allocations.
- Ms. Washington-Hendricks proposed a directive to support nutritional supplements for OH clients, especially liquid supplements for those who cannot eat solid food after a procedure. Mr. Vincent-Jones said Medication Assistance and Access (MA&A) funds such supplements, not OH. Currently, MA&A is an MO line item. Mr. Vega-Matos noted the need to coordinate nutritional supplements with MO.
- Mr. Johnson urged a plan to ensure linkage between OH and nutritional services driven by the data, e.g., the need for and barriers due to lack of co-location.
- Ms. Washington-Hendricks asked if hygienists could do educational workshops. Mr. Vega-Matos said they could do OH, not nutritional, workshops, but it would pull them from clients. There are currently MO nutritional workshops. Mr. Vincent-Jones noted that Medical Nutrition Therapy (MNT) was reprioritized at a higher ranking and the service could include related education.
- Ms. Jackson suggested flexibility in providing nutritional supplements, as consumers want to be to access them as close as possible to a current service provider. Mr. Vega-Matos added there are 23 MO providers and 8 OH providers, so access to nutritional supplements is greater through MO programs. Mr. Johnson said the issue pertains to medical

home and recommended looking at e-consults to improve coordination and ease staff time indicating that LIHP is moving towards the use of telemedicine.

- The Committee agreed that when FY 2012 Priority- and Allocation-Setting directives are determined at the end of the process, it should include a directive to explore approaches between MO and OH that coordinate nutritional counseling and improved access to nutritional supplements in FY 2012.

**MOTION #4** ***(Ballesteros/Liso)*****:** Re-allocate $269,785 in MAI YR 3 carryover funds from Early Intervention Services (EIS) to Oral Health (OH) **(*Passed: Ayes,*** Ballesteros, Johnson, Kelly, Land, Liso, Long, Lopez, Vega-Matos, Washington-Hendricks***; Opposed,*** none***; Abstentions,*** none**)**.

**MOTION #5** ***(Vega-Matos/Land)***: Modify MAI allocations in FY 2011 as follows: increase Oral Health (OH) from 20% to 30%; reduce Early Intervention Services (EIS) from 35% to 25%; and maintain the Medical Care Coordination (MCC) allocation level at 45% **(*Passed: Ayes,*** Ballesteros, Johnson, Kelly, Land, Liso, Long, Lopez, Vega-Matos, Washington-Hendricks***; Opposed,*** none***; Abstentions,*** none**)**.

**8. FY 2012 PRIORITY- AND ALLOCATION-SETTING PROCESS**:

**A. Contingency Funding Scenario Service Directives**:

- Mr. Vincent-Jones noted President Obama has requested 10% budget reduction scenarios from all departments to prepare for expenditure reductions in the next fiscal year.
- The Committee's contingency funding scenarios reflect both potential funding cuts and cost savings from the LIHP migration. FY 2010 figures are used as the final FY 2011 Ryan White awards have not yet been received.
- He noted P&P chose directives, not specific allocations, for all of the contingency funding scenarios beyond the base funding allocation to offer OAPP flexibility as the system changes. Mr. Vega-Matos said changes from funding cuts will be faster than from migration, but continuity of care remains key.
- Mr. Land asked if and when the Committee would need to request a waiver from the 75% core medical threshold. Mr. Vincent-Jones counseled the Committee to review the impact in each of the scenarios first as each scenario may call for a different strategy. Mr. Vega-Matos indicated that approximately 90% of Ryan White funds are now allocated/ contracted for core medical services. Mr. Vincent-Jones added that some scenarios may dictate the need for a waiver, while others might not: for example, the maximum number of clients migrating to the LIHP without any significant budget cuts (Scenario #3) may require a waiver, while the least number of clients migrating to the LIHP with the largest budget cuts (Scenario #7) may not necessitate it.
- Mr. Singer suggested looking at the net funding extremes: Scenarios #3, low LIHP migration and high cuts, for the least net resources; and Scenario #7, high LIHP migration and low cuts, for the most net resources. Other scenarios could be modified from those.
- Mr. Vega-Matos said if there were cuts, the system first needs to ensure the availability of basic core medical services, e.g., MO, OH, medical case management, and Mental Health. If there is surplus savings from migration to the LIHP MO, then he would want to maintain non-medical case management to coordinate care, OH because of the level of service need, other core medical services, and then wrap-around services not covered by the LIHP.
- Mr. Vincent-Jones said remaining need could support other allocation increases that the Committee and the Commission have discussed, such as for Medical Specialty and MNT.
- Ms. Jackson noted LIHP is more like conventional medical coverage, so those migrating out will need less of those services while other needs will remain. Mr. Vega-Matos added LIHP will offer some capped services, e.g., for mental health and substance abuse. A client might receive LIHP mental health services, reach the cap, and then need to turn to Ryan White-funded mental health services to ensure continuity of mental health care.
- Mr. Singer noted that, based on the financial projections in each of the contingency funding scenarios, the Ryan White system can absorb a positive or negative swing of about $2 million, so Scenarios #3, #5, and #6 were similar.
- The Committee agreed to start developing directives in those scenarios where the differences are more stark: Scenarios #4 and #7 (cost-savings scenarios) where LIHP migration increases with little budget change, Scenarios #2 and #3 (budget reduction scenarios) where there is a decreasing budget with little LIHP migration (Scenarios #2 and #3).

**B. Cost-Saving Scenario Directives (Scenarios #4 and #7)**: Allocations to the following service categories should be modified in the following manner in order of their priority rankings (as presented):

① Maintain the same level or increase Medical Outpatient/Specialty for clients remaining in RW system; any realized savings can be applied for these additional purposes:
- increase funding for treatment adherence services;
- increase support for lipodystrophy treatment, as allowed; and/or
- increase support to expand the availability of medical specialty services, as needed.

② Maintain or increase Medication Assistance and Access, as needed, to improve access to non-formulary medication assistance, including:
- increase support to improve availability of nutritional supplements.

③ Increase Oral Health Care.
④ Increase Linkage to Care Services, with emphasis on expanding treatment education services.
⑤ Increase Benefits Specialty to address expanded patient demand as patients migrate to other systems of care.
⑥ Maintain or increase Medical Care Coordination for expanded need to coordinate with patients in other systems of care.
⑦ Maintain support for services that the LIHP may cap, such as:
- mental health,
- substance abuse.

⑧ Increase Mental Health Services (psychiatry and psychotherapy):
- increase support for both psychiatry and psychotherapy services, and
- increased support for psychotherapy should be used, in part, to ensure continuity of care when gaps result from intern rotations.

⑨ Allocate to/increase Medical Nutrition Therapy.

- Mr. Singer suggested increasing Home-Based Case Management as programs are full. Mr. Vega-Matos said the service is undergoing various changes due to the implementation of the 1115 waiver and transfer of services from the State to OAPP. He urged no changes until OAPP could properly assess what is needed.

**C. Budget Reduction Scenario Directives (Scenarios #2 and #3)**: Allocations to the following service categories should be modified in the following manner:

① Preserve all core medical services possible to the extent possible
② Hold the following services harmless (maintain their allocations at the expense of cuts to other service categories), in order of their priority rankings (as presented):
- Medical Outpatient/Specialty
- Medication Assistance and Access
- Oral Health
- Linkage to Care Services
- Benefits Specialty
- Medical Care Coordination
- Mental Health Services (Psychiatry and Psychotherapy).

③ Cut whole service categories from the lowest priority ranked up as funds become unavailable

- Mr. Vega-Matos noted OAPP has leeway to cut contracts if needed, as demonstrated when forced to address harsh State budget cuts two years ago.
- Mr. Singer raised concerns about cutting whole service categories rather than implementing across-the-board budget reductions to multiple services to the extent needed. Mr. Vincent-Jones responded that the Committee has explored the distinction between the two alternatives when it has done contingency planning in the past, and concluded that eliminating entire service categories is more effective when faced with such significant budget cuts.
- Mr. Vega-Matos added that discussion centered around the need for service categories to minimum certain sustainable funding thresholds before it becomes ineffective (e.g., .1% for a service category does not yield effective services), and that allocations to most of the lower priority-ranked services are already close to minimum threshold levels.
- He also said that eliminating an entire service category is a much more effective way to pressure other systems to step-up their support for those services than reducing those service allocations to ineffective levels.
- ➲ Mr. Vincent-Jones and Ms. Pinney will draft a grid based on the foregoing directives for Scenarios #2, #3, #4, and #7 to facilitate decision-making for the remaining contingency funding scenario directives.

**9. NEXT STEPS**:

- The Committee will resume development of contingency funding scenario directives for the remaining scenarios at its next meeting will be 9/2/2011, 9:30 am to 12:00 noon.
- Mr. Vincent-Jones noted that once the Committee completed the development of contingency funding scenarios, it would need to review the SPA 1 allocation threshold and determine if and when the Grantee should submit a request to waive the 75% core medical service threshold requirement to HRSA.
- He added that the Committee will also need to assess if it must revise FY 2011 allocations once OAPP receiving the funding notice from HRSA. He indicated that the Committee may not need to if the award is relatively flat-funded and given more than half of the fiscal year has already passed, and the Committee must begin considering underspending revisions in the next two to three months.

**10. ANNOUNCEMENTS**: There were no announcements.

**11. ADJOURNMENT**: The meeting adjourned at 4:20 pm.